BALDWINSVILLE CENTRAL SCHOOL DISTRICT
Baldwinsville, New York 13027

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me **and brought to school by me or authorized adult** in the properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person will administer the medication.

Name of Medication: _____

Signature (parent or guardian): _____

TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER

I request that my patient, as listed below, receive the following medication:

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

(For Epi-pens/Inhalers only) Student may carry and self administer : Yes No (Circle One)

Prescribed Dosage: _____

Time To Be Taken During School Hours: _____

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

_____

Name of Licensed Prescriber and Title (please print): _____

Phone Number: _____

Prescriber's Signature: _____ Date: _____

1/26/06